



ESM Client ID:

Provider ID:

Intake Form
Standard► ESM Release of Information: ☐ Yes ☐ No► Enrollment Date: / /
 mm dd yyyy

ALL QUESTIONS MARKED WITH A ► MUST BE COMPLETED.

1. First Name:	Middle Initial:	Last Name:	Suffix:
► 2. Highest Grade Completed:			
<input type="checkbox"/> Not of school age	<input type="checkbox"/> High school diploma/GED	<input type="checkbox"/> College degree or higher	<input type="checkbox"/> No formal education
<input type="checkbox"/> Some schooling, no high school	<input type="checkbox"/> Some college	<input type="checkbox"/> Other credential (degree, certificate)	<input type="checkbox"/> Unknown
<input type="checkbox"/> Some high school	<input type="checkbox"/> Associates degree		
► 3. Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/>		► 4. Birth Date: / / mm dd yyyy	
► 5. SSN:		If client refuses to give SSN or it is unknown, enter 999-99-9999	

PERSONAL INFORMATION>ADDRESS

► 6a. Address Type: Home <input type="checkbox"/> Near Homeless <input type="checkbox"/> Homeless <input type="checkbox"/> See Job Aid in the Intake Manual to determine Homeless vs. non-Homeless!		
If Address Type is "Homeless", only enter the city/town and zip code where client is usually homeless. Do not use the Program's city/town/zip.		
► Street Address:		Unit:
► City/Town:	► State:	► Zip code:
► 6b. Is this your Primary Address? Yes <input checked="" type="checkbox"/>		

ALTERNATE NAME Section

If client has an alternate name, complete the following:	
7a. First Name:	Middle Initial: Last Name:
7b. Name Type: Alias <input type="checkbox"/> Nickname <input type="checkbox"/> Known by <input type="checkbox"/> Married Name <input type="checkbox"/> Maiden Name <input type="checkbox"/> Name at Birth <input type="checkbox"/> Prior Marriage Name <input type="checkbox"/>	

DEMOGRAPHICS>CULTURAL CHARACTERISTICS

► 8a. Are you Spanish/ Hispanic/Latino? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If 'yes' to Question 8a, complete Question 8b. If 'no' to Question 8a, go to Question 9		
8b. Which of the following ethnicities best describes you?		
<input type="checkbox"/> Central American	<input type="checkbox"/> Mexican, Mexican American, Chicano	<input type="checkbox"/> South American
<input type="checkbox"/> Cuban	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Unknown
<input type="checkbox"/> Dominican	<input type="checkbox"/> Salvadoran	<input type="checkbox"/> Other, specify _____
If 'no' to Question 8a, Select one from below		
9. What is your primary Ethnicity/Ancestry? (select one only)		
<input type="checkbox"/> African	<input type="checkbox"/> Chinese	<input type="checkbox"/> Latin American Indian
<input type="checkbox"/> African American	<input type="checkbox"/> Eastern European	<input type="checkbox"/> Middle Eastern
<input type="checkbox"/> American	<input type="checkbox"/> European	<input type="checkbox"/> Portuguese
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Russian
<input type="checkbox"/> Brazilian	<input type="checkbox"/> Haitian	<input type="checkbox"/> Thai
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Cape Verdean	<input type="checkbox"/> Korean	<input type="checkbox"/> Unknown
<input type="checkbox"/> Caribbean Islander	<input type="checkbox"/> Laotian	<input type="checkbox"/> Other, specify _____

► **10. What is your race?** (check all that apply)

<input type="checkbox"/> American Indian/Alaskan Indian	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Unknown
<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Refused
<input type="checkbox"/> Black, African American	<input type="checkbox"/> Other, specify: _____	

► **11. In what language do you prefer to read or discuss health related materials?**

<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Haitian Creole	<input type="checkbox"/> Russian
<input type="checkbox"/> Cambodian (Khmer)	<input type="checkbox"/> Hmong	<input type="checkbox"/> Spanish
<input type="checkbox"/> Cape Verdean Creole	<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Laotian	<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> English	<input type="checkbox"/> Portuguese	

HOUSEHOLD CHARACTERISTICS Section► **12. Number of Adults in Household:**
(if client is Homeless, enter 1)**13. Number of Children Living in Household** (children under 19):
(children currently living with the client whether or not related)► **14a. Client Income: \$****14b. Income Frequency:** ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually**15. Source of Income:** (Check all that apply)

<input type="checkbox"/> Wages/Salary	<input type="checkbox"/> Veterans Disability Payment	<input type="checkbox"/> Retirement - Social Security
<input type="checkbox"/> Child Support	<input type="checkbox"/> Private Disability Payment	<input type="checkbox"/> Retirement/Pension - Private
<input type="checkbox"/> Alimony	<input type="checkbox"/> Public Assistance - TANF	<input type="checkbox"/> Veterans Pension
<input type="checkbox"/> Disability	<input type="checkbox"/> Public Assistance - General	<input type="checkbox"/> Non-employment Cash Income
<input type="checkbox"/> Disability - SSI	<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> None
<input type="checkbox"/> Disability - SSDI	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> Other

16. Received Income Verification: ☐► **17. Marital Status:** ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Significant Partnership Rlat.**INSURANCE Section** (Data Entry: To get to Insurance section, return to Face Sheet and select Insurance link on left side of screen.)► **18. Insurance Type:**

<input type="checkbox"/> Uninsured	<input type="checkbox"/> MC (Medicaid / MassHealth / MBHP)	<input type="checkbox"/> MP (Medicare –Over 65-some disabled)	<input type="checkbox"/> VA (Veterans Administration)
<input type="checkbox"/> HM –(HMO) (Private HMO – through employment or client pay)	<input type="checkbox"/> CI (Private Insurance – through employment or client pay with no subsidy)	<input type="checkbox"/> OT (Other - Includes State subsidy – ConnectCare / Health Safety Net)	

► Insurance Company Name:

Not required if uninsured

Policy Number:

Data Entry: **If entering a New insurance record, enter the Enrollment Date as the Insurance Effective Date.**
If existing client with new insurance, end date previous insurance record with day before this Enrollment Date
If existing client and the insurance has Not Changed since the client's last enrollment (whether or not at your program), simply hit SAVE!!!

► **19. Is this your Primary Insurance?** Yes ☐ No ☐**If the client has additional insurance coverage, complete the following. If not, intake is complete.****20. Insurance Type: Note: Uninsured is not an option here under additional insurance.**

<input type="checkbox"/> MC (Medicaid / MassHealth / MBHP)	<input type="checkbox"/> MP (Medicare –Over 65-some disabled)	<input type="checkbox"/> VA (Veterans Administration)
<input type="checkbox"/> HM –(HMO) (Private HMO – through employment or client pay)	<input type="checkbox"/> CI (Private Insurance – through employment or client pay with no subsidy)	<input type="checkbox"/> OT (Other - Includes State subsidy – ConnectCare / Health Safety Net)

► Insurance Company Name:

Policy Number: